with comparable costs. Therefore, an incremental cost-effectiveness ratio was calculated. Due to the possibility of declining adherence to drug therapy over time, pelvic floor physical therapy can be considered as the first line treatment for UUI.

PUK17

THE COST IMPLICATIONS OF RENAL DENERVATION THERAPY AT THE HOSPITAL LEVEL IN THE UNITED KINGDOM

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OBJECTIVES: Hypertension is a chronic medical condition and an important risk factor in several fatal and debilitating diseases. NICE estimates the cost of pharmacologic intervention in the UK for hypertension at £409.8 million. Resistant hypertension arises when blood pressure remains uncontrolled despite antihypertensive treatment. Renal denervation is a new procedure aimed at reducing blood pressure in resistant hypertension patients by decreasing efferent sympathetic signalling to the kidneys. The objective of this research was to review the evidence on the cost of renal denervation and to provide a costing model for the procedure. **METHODS:** A targeted review of costing data was performed and information gathered from renal denervation experts to establish relevant procedure costs. Once specific health care resource use (HRU) and equipment costs were identified, an Excel™ costing model was constructed. A further search of NHS costing documents, academic literature, and expert consultation provided GBP figures for each cost and identified those that were time dependent (e.g. hourly staff costs). **RESULTS:** The required in-patient HRU was identified as staff costs per hour including surgeon costs, nurse costs, technician costs and anaesthesiologist costs, all of which vary with procedure time depending on the device used (ranging from 20-60 minutes). Catheter lab overhead costs per hour and recovery costs (bed days) were also identified. Total HRU costs vary between £923.02 and £991.62 (for 20 and 60 minute procedure times respectively). An additional in-hospital recovery day adds £680. Equipment costs were for 12 items including from syringes to catheters to valves, totaling £281.70 plus the cost of the renal denervation therapy device. **CONCLUSIONS:** It is essential the cost of the procedure is estimated to fully inform payers and health care providers. HRU costs are dependent on procedure time and length of recovery in hospital, thus devices that reduce these factors are best for cost savings.

PUK18

LONG-TERM COSTS AND SURVIVAL ASSOCIATED WITH IMMUNOSUPPRESSANT FOLLOWING LIVER TRANSPLANTATION: A MARKOV MODEL

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OBJECTIVES: Despite significant improvements in survival and quality of life (QoL) of liver transplant (LTx) recipients, patients remain at risk from complications related to disease recurrence and long-term use of immunosuppressant (IS). The objective was to assess cost, survival, and QoL outcomes of LTx recipients and the impact of renal dysfunction on LTx outcomes. **METHODS:** A *de novo* cohort Markov model was developed to predict long-term outcomes post LTx along two independent pathways: 1) liver-related (acute rejection, hepatocellular carcinoma, hepatitis C (HCV) recurrence, graft loss), 2) kidney-related (chronic kidney disease, dialysis, renal transplantation) and death. All patients, stratified by liver diagnosis, entered the model at time of LTx and followed both pathways, allowing for multiple combinations of liver and kidney health states. Costs and utilities were assigned to each health renal and liver state. Renal complications costs and utility decrements were added to those accrued in the liver pathway. The lifetime model used an annual cycle length except for the 1st year post LTx (quarterly). Choice of immunosuppressant strategy could impact the risk of acute rejection, change in renal function and HCV fibrosis progression. A 3% discount rate was applied to costs and outcomes. **RESULTS:** On average, life expectancy post LTx was 13.3 years with 10.2 QALYs. Lifetime cost of managing post LTx recipients was USD 550,000 (excluding LTx procedure): >50% was related to IS regimen, monitoring and adverse events; around 40% to renal complications and 2-7% to liver complications. Patients developing renal dysfunction lost 5.2 life-years and 1.5 QALYs. **CONCLUSIONS:** To our knowledge, this is the first Markov model simulating lifetime costs and outcomes post-LTx and the impact of change in renal function on patient survival. A health care intervention that could improve or maintain renal function would have significant impact on survival and costs.

PUK19

COST-EFFECTIVENESS OF FESOTERODINE AND TOLTERODINE FOR THE TREATMENT OF OVERACTIVE BLADDER WITH URGE URINARY INCONTINENCE IN SPAIN AND FINLAND

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OBJECTIVES: To assess the economic value of fesoterodine compared to tolterodine for the treatment of overactive bladder (OAB) with urgency urinary incontinence (UUI) in Spain and Finland. **METHODS:** A decision-tree economic model estimated the 52-week costs and quality-adjusted life years (QALYs) of OAB/UUI patients initiating treatment with fesoterodine 4mg/day or extended-release (ER) tolterodine. Treatment response (UUI <1 episode/day) and persistence were evaluated at weeks 4, 12, and 24. Titration from fesoterodine 4mg/day to 8mg/day was permitted at week 4. At week 12, non-responders discontinued treatment permanently. Efficacy, discontinuation, and utility data were derived from four clinical trials of fesoterodine. OAB-related costs including physician visits, laboratory tests, incontinence pads, and comorbidities (fracture, skin infection, urinary tract infections, depression, and nursing home) were also included. The perspective was that of the National Health Systems (2012€). Uncertainty surrounding the model parameters was assessed by univariate and probabilistic sensitivity analysis (PSA). **RESULTS:** A total of 19.5% and 18.0% of fesoterodine and ER tolterodine patients remained on treatment until week 52, respectively. QALYs were higher with fesoterodine than tolterodine (0.762 vs. 0.760). In Spain, fesoterodine treatment had higher costs than (generic) ER tolterodine (€6 697 vs. €6 597), resulting in a cost of €15 600/QALY gained. In Finland, fesoterodine was cost-saving relative to (non-generic) ER tolterodine (€7 885 vs. €8 024). Sensitivity analysis confirmed these findings were robust to the expected price decrease for generic ER tolterodine in Finland. In the PSA, fesoterodine was consistently the preferred therapy in Finland regardless of the value of a QALY and in Spain for QALY valuations greater than €15 000. **CONCLUSIONS:** Fesoterodine is cost-effective or cost-saving relative to ER tolterodine for the treatment of OAB with UUI in two European countries. Payers and prescribers should consider a broad scope of costs in order to make informed cost-conscious choices of antimuscarinic treatment.

PUK20

ECONOMIC EVALUATION OF PHARMACOLOGICAL TREATMENTS FOR OVERACTIVE BLADDER

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OBJECTIVES: Overactive bladder (OAB) is a chronic condition which affects quality of life through the main symptoms of urinary urgency, urinary frequency, and urinary incontinence. Treatments include behavioural therapy, antimuscarinics (AM), β_3-adrenoceptor agonsits (mirabegron), botulinum toxin (botox) and sacral nerve stimulation (SNS). The aim of this analysis was to evaluate the costs and outcomes associated with different sequences of oral treatments (AM and mirabegron). **METHODS:** A Markov model with monthly cycle length and a time horizon up to 3 years compared two different sequences of up to three lines of oral treatments. Patients who discontinue one oral medication may switch to another oral medication, or may discontinue treatment. Patients whose symptoms are not improved are considered for botox or SNS. Outcomes are measured by (a) number of patients with improved symptoms (< 2 incontinence episodes and < 8 micturitions per 24-hours); (b) patients with < 2 incontinence episodes per 24-hours; and (c) patients with < 8 micturitions per 24-hours. **RESULTS:** Including a third-line oral medication before considering other treatment options improved all patient outcomes, irrespective of the particular drugs used. A three-line sequence including two generics (oxybutynin (1st line), and tolterodine ER (2nd line)), and one branded drug (solifenacin 5mg (3rd line)) resulted in inferior patient outcomes and higher cost compared with a sequence of branded drugs (mirabegron (1st line), solifenacin 5mg (2nd line), solifenacin 10mg (3rd line)): improved patients (70/1000 vs. 92/1000); patients with < 2 incontinence episodes (181/1000 vs. 217/1000); patients with < 8 micturitions (248/1000 vs. 299/1000). Annual treatment costs were higher in the generic sequence (£2659 per patient vs. £2479). **CONCLUSIONS:** Low-cost generic treatments are not necessarily more cost-effective than branded drugs. The main reason is that a better efficacy and tolerability balance improves symptoms and quality of life, leading to better persistence and lower overall treatment costs.

PUK21

COST-EFFECTIVENESS OF MIRABEGRON COMPARED WITH TOLTERODINE ER 4MG FOR THE TREATMENT OF PATIENTS WITH OVERACTIVE BLADDER IN THE UNITED KINGDOM: RESULTS FROM A TRIAL-BASED MODEL

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OBJECTIVES: Mirabegron is a first-in-class beta-3 adrenoceptor agonist for the treatment of overactive bladder (OAB) that demonstrated superior efficacy compared to placebo in OAB. The cost-effectiveness of mirabegron 50 mg (MGN) was assessed in comparison with tolterodine ER 4 mg (TOL) in the UK. **METHODS:** A Markov model was developed to simulate the therapeutic management, the changes in symptoms (micturitions and incontinence), and complications in OAB patients. The model was used to predict costs and QALYs over 5 years in cohorts initially treated with MGN or TOL, followed by antimuscarinics in case of lack of efficacy or adverse events. Transition probabilities and EQ-5D utilities were obtained from regression models, estimated from a P3 randomized controlled trial of mirabegron. Costs were evaluated from the UK National Health Service (NHS) perspective and included drug acquisition, physician visits, pads and botulinum toxin injections. Subgroup analyses were performed for previously treated, treatment naïve, incontinent, female and elderly patients. **RESULTS:** The MGN strategy was more expensive compared to TOL, with a difference of £37.88 per patient, and produced more QALYs (+0.009 per patient). The incremental cost-effectiveness ratio (ICER) was estimated at £4,386/QALY gained. Results of one-way sensitivity analyses showed that in all scenarios, except one (the transition probabilities between symptom levels of micturition for mirabegron), MGN remained cost-effective or was dominant compared to TOL. Key cost-effectiveness drivers included parameters related to efficacy and treatment discontinuation. Based on the probabilistic sensitivity analysis, the probability of MGN being cost-effective against TOL was 89.4% at a threshold of £20,000 per QALY gained. ICERs in subgroups ranged from £3,091 (female subgroup) to £5,736 (elderly subgroup). **CONCLUSIONS:** Treatment with mirabegron 50 mg appears to be a cost-effective strategy compared with tolterodine ER 4 mg for the general OAB population and the specified subgroups, from a UK NHS perspective.

PUK22

COST-EFFECTIVENESS OF MIRABEGRON COMPARED WITH ANTIMUSCARINICS FOR THE TREATMENT OF PATIENTS WITH OVERACTIVE BLADDER IN THE UNITED KINGDOM

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OBJECTIVES: Mirabegron is a first-in-class beta-3 adrenoceptor agonist for the treatment of overactive bladder (OAB) that demonstrated superior efficacy compared to placebo by reducing OAB symptoms and improving HRQoL. We sought to assess the cost-effectiveness of mirabegron 50 mg in comparison with current antimuscarinics for the treatment of patients with OAB in the UK. **METHODS:** A Markov model was developed to simulate the therapeutic management, the changes in symptoms (micturitions and incontinence), and complications in hypothetical cohorts of OAB patients. The model was used to predict costs and QALYs over 5 years in cohorts initially treated with antimuscarinics or mirabegron 50mg. Effectiveness and safety data were based on the results from a mixed treatment comparison (MTC). A calibration approach was used to derive transition probabilities from mean changes in frequency of micturitions and incontinence episodes. Other input data were obtained from several sources, including scientific literature and expert opinions. Costs were evaluated from the UK National Health Service (NHS) perspective and included costs of drug acquisition, GP visits, specialist visit, incontinence pad use and botox injections. Utilities were obtained from equations predicting EQ-5D index scores according to symptom severity, estimated from a clinical trial of Mirabegron. **RESULTS:** The Mirabegron strategy was slightly more expensive and associated with a greater number of QALYs, as a result of improved persistence, related to a lower risk of adverse event compared to each antimuscarinic. Mirabegron 50mg was found to be cost-effective compared to each antimuscarinic, with an ICER of £340 vs. solifenacin 10mg, £3,607 versus fesoterodine 4mg, £3,715 vs. tolterodine ER 4mg, £3,878 vs. oxybutynin ER 10mg, £8,881 versus trospium chloride MR 60 mg, £12,493 versus solifenacin 5mg, and £14,234 oxybutynin IR 10mg. **CONCLUSIONS:** Treatment with mirabegron appears to be a cost-effective strategy compared with antimuscarinics from a UK NHS perspective.

PUK23

COST-MINIMIZATION ANALYSIS OF FERUMOXYTOL IN THE MANAGEMENT OF ANEMIA IN PATIENTS WITH CHRONIC KIDNEY DISEASE IN BELGIUM

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OBJECTIVES: Intravenous (IV) irons are second line treatments for iron deficiencies in severe chronic kidney disease (CKD) patients with iron deficiency anaemia. Aim of this study was to compare ferumoxytol, a new agent, against IV ferric carboxymaltose (FC) and IV iron sucrose (IS), from a Belgian health care payer (BP) and hospital perspective (HP). **METHODS:** The CKD patients were categorized in haemodialysis (HD), peritoneal dialysis (PD), non-dialysis (post-renal transplant and non-dialysis) and all patients combined. The available IV irons have a similar efficacy. Adverse events were not included due to missing comparative data and low rates. However, the administration time and number of administrations differ among treatments. So a cost-minimization analysis was conducted (time horizon: 1 year). The average annual need of IV Iron is 3,500 mg in HD, 2,500 mg in PD and 1,500 mg in non-dialysis patients. The hospital perspective was modelled by deducting the nurse time cost from the hospital fee per administration (HP). For the health care payer the administration cost (hospital fee) and the drug costs are included (BP). Other costs were excluded because they did not affect the incremental cost of treatment. **RESULTS:** The total cost (euro 2012) for all patients was € 676.57, € 819.82 and € 617.34 for ferumoxytol, FC and IS, respectively (BP). In the renal transplant and non-dialysis subgroups, ferumoxytol is less costly than FC and IS (BP). In the HD subgroup (86.77% of all eligible patients), IS is the least costly option (BP). The hospital cost in all patients is higher with IS due to more nurse time (€ 101.31, € 7.58 and € 144.19 for ferumoxytol, FC and IS) (HP). **CONCLUSIONS:** Hospitals benefit from lower administration costs with ferumoxytol and FC (HP). From a Belgian payer perspective, ferumoxytol is less costly than FC and more costly than IS.

PUK24

HEALTH CARE RESOURCE UTILIZATION COSTS RELATED TO ANAEMIA MANAGEMENT IN CHRONIC KIDNEY DISEASE NON-DIALYSED PATIENTS: A RETROSPECTIVE CLINICAL AND ADMINISTRATIVE DATABASE ANALYSIS

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OBJECTIVES: Anaemia is a frequent complication among patients with Chronic Kidney Disease (CKD) and is associated with poor outcomes. European data on the patterns of treatment of anaemia in non-dialysed (ND) CKD patients are scarce. The aim of this study was to describe the anaemia-associated Health Resource Utilization (HRU) in an Italian cohort of ND-CKD patients. **METHODS:** The administrative data and clinical laboratory files of 5 Italian Local Health Units from 2006 to 2011 were used to identify ND patients with CKD (stage3b, 4, 5) and anemia. Anaemia-related HRU and associated costs were investigated. **RESULTS:** A total of 1175 patients were included; 790 in CKD stage 3b; 331 in stage 4; 54 in stage 5. Anaemia-related medications were prescribed to 31.9% of patients and the percentage increased along the CKD stages from 28.9% for stage 3b to 42.6% for stage 5. Among the drug-treated patients Erythropoiesis-stimulating agents were prescribed to 82.6% of CKD stage 5 patients whereas CKD stage 3b patients received mostly oral iron (59.6%). Patients receiving any anaemia-related medications had lower per patient-per year cost for almost all studied resources compared to patients not receiving any medications. For anaemia-related outpatient services [drug-treated and not drug-treated]: stage 3b costs per patient year were €62.12 and €62.32 respectively; stage 4 costs were €52.23 and €72.76; stage 5 costs were €55.83 and €83.08. For general visits: stage 3b costs were €168.51 and €170.28; stage 4 costs were €124.17 and €173.79; stage 5 costs were €134.49 and €343.63. For CV hospitalizations: stage 3b costs were €1378.63 and €1828.60; stage 4 costs were €1185.17 and €2155.82; stage 5 costs were €521.61 and €514.63. **CONCLUSIONS:** Among ND CKD patients drug treatment may help control anaemia-related outpatient services and contain CV hospitalization costs and represents an opportunity for health care improvement.

URINARY/KIDNEY DISORDERS – Patient-Reported Outcomes & Patient Preference Studies

PUK25

IMPLICATIONS OF NON-ADHERENCE TO PHOSPHATE BINDERS ON PATIENTS' PHOSPHATE LEVELS

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OBJECTIVES: Elevated serum phosphate (hyperphosphataemia) usually accompanies end-stage renal disease and results from the inability of damaged kidneys to effectively regulate phosphate levels. Failure to maintain adequate phosphate balance has important clinical consequences, with an increased morbidity and risk of mortality. When dietary phosphate restriction is inadequate for control, administration of phosphate binders may be required. A number of phosphate binders are currently available; however, these often require high doses to control serum phosphate levels and this may result in lowered patient compliance. The objectives of this research were to assess the pill burden associated with phosphate binders and highlight any links between pill burden, patient adherence and outcomes in terms of serum phosphate levels. **METHODS:** A literature review was performed using the PubMed database using the search term "phosphate binders AND adherence". Twenty six articles were identified in total, with ten relevant articles. **RESULTS:** Six of the ten relevant articles (60%) found that low patient adherence or high pill burden were associated with higher mean serum phosphate level, whereas only one article (10%) concluded that no link existed. Seven articles reported dose increases with phosphate binder treatment or an increased number of pills per patient per day over the treatment course, with two reporting that the actual dose of phosphate binders in clinical practice was higher than those recommended in clinical guidelines. A high pill burden was found to lead to low adherence by three of the articles identified (30%), whereas only one of the papers identified did not support this hypothesis (10%). **CONCLUSIONS:** This research indicates that there is a high pill burden associated with phosphate binders, as well as a requirement in clinical practice for high dosages. There is a suggestion that these factors are linked to low patient adherence and poorer control of serum phosphate levels.

PUK26

IMPACT OF MAJOR CLINICAL EVENTS ON UTILITIES IN THE CONTEXT OF SECONDARY HYPERPARATHYROIDISM (SHPT) AND CHRONIC KIDNEY DISEASE (CKD) TREATED WITH DIALYSIS

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OBJECTIVES: Health economic evaluations of therapeutic interventions in patients with CKD and SHPT requiring dialysis (CKD-SHPT) should incorporate the impact of major clinical events related to their disease. However, little is known about the disutility (i.e, utility decrease) associated with cardiovascular (CV) and fracture events in the context of CKD-SHPT. The purpose of this study was to estimate, via preference-based valuation completed by general population respondents, the added disutility of these events beyond the impact of CKD-SHPT. **METHODS:** One-year health states were developed describing CKD-SHPT and related CV/fracture acute events/procedures. Events with long-term effects (post one year) were also captured in chronic health states. General population participants in Canada completed time trade-off (TTO) interviews to assess health state utilities. Respondents initially rated the CKD-SHPT health state. Then, events and procedures were added to this health state: myocardial infarction (MI); unstable angina (UA); heart failure exacerbation; peripheral vascular disease (PVD) ± amputation; stable angina (SA); stroke; hip/arm fractures; parathyroidectomy; kidney transplant. Each participant was randomly-assigned 11 of 16 health states to rate. **RESULTS:** A total of 199 participants (54.8% female; mean age = 46.3 years) completed interviews. Each health state had ≥130 valuations. CKD-SHPT had a mean utility of 0.60 (SD=0.34). For acute events, mean utility decrements additional to CKD-SHPT were: MI, -0.06; UA, -0.05; PVD with amputation, -0.33; PVD without amputation, -0.11; heart failure, -0.14; stroke -0.30; hip fracture, -0.14; arm fracture, -0.04; parathyroidectomy, +0.02; kidney transplant, +0.06. Disutilities for chronic effects were: SA, -0.09; stroke -0.27; PVD with amputation -0.30; PVD without amputation, -0.12; heart failure, -0.14. **CONCLUSIONS:** Valuation of health states representing CKD-SHPT plus major clinical events was feasible using TTO with a one-year time horizon. These data will assist investigators in applying appropriate disutilities to clinical events in economic evaluations of treatments for patients with CKD-SHPT requiring dialysis.

PUK27

THE IMPACT OF SACRAL NEUROMODULATION ON EQ-5D INDEX SCORES AND COSTS TO MANAGE OVERACTIVE BLADDER

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OBJECTIVES: To determine the impact of sacral neuromodulation (SNM) on EQ-5D index scores and OAB management costs using an Economic Impact Questionnaire (EIQ) in patients who failed at least one anticholinergic medication enrolled in the InSite study, an ongoing, prospective, multicenter trial of SNM. **METHODS:** EQ-5D and EIQ were administered at baseline, 3-, 6- and 12-months post-implant. OAB-related expenses included durable and disposable medical supplies and health service utilization (emergency room, hospitalizations and outpatient). A total of 340